

Application for Dentists Professional Liability Insurance

www.MLMIC.com

IMPORTANT NOTICE

Coverage is available to qualifying New York State Dentists, on either an occurrence policy form or a claims made policy form. (Please note your choice below).

If you select the claims made policy form, please be aware that NO coverage will be extended for any incidents, occurrences or alleged wrongful acts which took place prior to the Retroactive Date stated in the policy.

Under the claims made policy form coverage is only provided for incidents that occur on or after the Retroactive Date stated in the policy and which are reported to the Company while the policy is in effect or within 60 days following termination of insurance, unless additional reporting period coverage (Optional Extended Reporting Endorsement) is purchased which would provide an unlimited time period to report covered Claims.

During the first several years, claims made premiums are lower than occurrence premiums but then they increase gradually, independent of overall rate level increases, until the claims made risk reaches maturity.

All applications are subject to prior approval. *If your application is approved, coverage can be provided no earlier than the day following our receipt of the signed and completed application.*

Answer ALL questions. An incomplete application cannot be evaluated. If a question is not applicable, state N/A.

Preliminary Questions

Are you newly licensed in New York? Yes No
 Have you just completed your GPR? Yes No
 Are you an Oral Surgeon? Yes No

General Information

Last Name _____ First Name _____ Middle Name _____ Date of Birth _____

License Number _____ NPI Number _____ E-Mail Address _____

Principal Office Phone Number _____ Cell Phone Number _____ Home Phone Number _____ Fax Number _____

Mailing Address:

Address Line 1 _____ Address Line 2 _____

City _____ State _____ Zip Code _____ County _____

Home Address: Same as Mailing Address: Yes No

Address Line 1 _____ Address Line 2 _____

City _____ State _____ Zip Code _____ County _____

List all professional office locations requiring coverage from us and percentage (%) of patient hours at each. MUST TOTAL 100%.

Street _____ City _____ State _____ Zip Code _____ County _____ % of time _____

Street _____ City _____ State _____ Zip Code _____ County _____ % of time _____

Street _____ City _____ State _____ Zip Code _____ County _____ % of time _____

Street _____ City _____ State _____ Zip Code _____ County _____ % of time _____

Street _____ City _____ State _____ Zip Code _____ County _____ % of time _____

Are any of the above locations a prison/jail, hospital or nursing home? Yes No

Applicant Name: _____

General Information (continued)

Are you practicing at a location where coverage is already being provided by another carrier? Yes No

If yes, please provide a copy of the declarations page of the policy.
(Please note, coverage for this location will be excluded from this policy)

On what date do you wish the insurance to be effective? 12:01 A.M. Standard Time on: _____

On which basis do you wish your policy issued? Claims Made Occurrence

Select limits of liability you wish the policy to provide:

(*Note: Only Limit Available for New Dentist Flat Rate)

- \$1,000,000 Each Person/\$3,000,000 Total*
- \$1,300,000 Each Person/\$3,900,000 Total
- \$2,000,000 Each Person/\$6,000,000 Total

Other limits may be available upon request.

Have you ever had professional liability insurance? Yes No

If yes, provide the following information with respect to all past insurance coverage.

Company Name			Policy Number
Coverage Effective Date	Coverage Expiration Date	Limits of Liability	Type of Coverage
Company Name			Policy Number
Coverage Effective Date	Coverage Expiration Date	Limits of Liability	Type of Coverage
Company Name			Policy Number
Coverage Effective Date	Coverage Expiration Date	Limits of Liability	Type of Coverage
Company Name			Policy Number
Coverage Effective Date	Coverage Expiration Date	Limits of Liability	Type of Coverage

The following questions must be completed by all applicants who were covered on a claims made basis by their prior carrier:

If your immediate past insurance coverage was written on a claims made policy form, do you intend on purchasing Optional Extended Reporting Endorsement ("Tail") coverage from your prior carrier? Yes No

PLEASE NOTE: If you select claims made coverage with MLMIC, it will only provide protection for incidents which both occur and are reported on or after the effective date of your policy unless you secure Prior Acts "Nose" coverage from the Company. (See Request for Prior Acts ("Nose") Coverage)

Request for Prior Acts ("Nose") Coverage

This section should only be completed if you meet the following requirements:

- You are presently covered on a claims made basis by a New York State admitted carrier.
- You are not purchasing Optional Extended Reporting Endorsement "Tail" coverage from your prior carrier.
- There is no coverage lapse between the cancellation date of your current claims made policy and the requested effective date of your MLMIC coverage.

For what period of time are you requesting "Nose" coverage? _____
From (MM/DD/YYYY): _____ To (MM/DD/YYYY): _____

A copy of the declaration page of the policy (or policies), including all endorsements in effect during the period for which you are requesting "Nose" coverage must accompany your application. If this information is not included, it will delay the processing of your application.

Applicant Name: _____

Education Information

Dental School Attended:

Name						Degree
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City	State	Country	From	To	Year Graduated
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If you are a Foreign Dental School graduate, are you certified by the State Board of Dental Examiners? Yes No

What United States dental school did you attend?

Name						Degree
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City	State	Country	From	To	Year Graduated
------	-------	---------	------	----	----------------

Other training - including GPR and specialty training

Name of School/Institution		
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City	State/Country
------	---------------

From	To	Degree
------	----	--------

Type of Training

Name of School/Institution		
----------------------------	--	--

City	State/Country
------	---------------

From	To	Degree
------	----	--------

Type of Training

Please enter your NYS License information:

Type of License	License Number	Date Licensed
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Do you hold any other professional licenses? (Active or Inactive) Yes No

Type of License	State	License Number	Date Licensed
-----------------	-------	----------------	---------------

Type of License	State	License Number	Date Licensed
-----------------	-------	----------------	---------------

Type of License	State	License Number	Date Licensed
-----------------	-------	----------------	---------------

Have you completed a Risk Management Course within the past 2 years? Yes No

If yes, please provide course Certificate of Completion.

Practice Information

Do you hold any hospital staff appointments? Yes No

List current hospital staff appointment(s), including any for which you are applying and estimate annual number of patients admitted by you:

Name of Hospital	Estimated Number of Admissions
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Would you like certification of insurance sent to above hospital(s)? Yes No

Applicant Name: _____

Practice Information (continued)

Have you ever practiced at any location(s) other than your current office address? Yes No

List locations where you have practiced to date:

City	State	Country	From Date	To Date

NYSDA Status: (Enter the District name or Non-Member) _____

CADA Status: (Enter Member or Non-Member) _____

What is your ADA number? _____

List all other professional societies (national, state, county, other) of which you are a member:

As of the effective date of this insurance, specify the nature of your current practice (please check all that apply):

- Solo Practitioner
- Solo Professional Corporation (P.C.)
- Multi-Dentist Professional Corporation (P.C.)
- Part of a DSO
- Independent Contractor
- Professional Association (P.A.)
- Partnership

What are the total hours per week for which you require coverage from MLMIC? 0-20 hours 21-40 hours 40+ hours

(Note: New dentists applying for Flat Rate must be full time.

Average patients per day: _____ per week: _____

If your office is open, and your employees are working, you must include these hours.)

Are you an employee of a Professional Partnership, Professional Limited Liability Partnership, Professional Service Corporation, Professional Limited Liability Company, or an individual dentist? Yes No

If yes, provide name(s) of employers(s):

Are you a partner of a Professional Partnership, Professional Limited Liability Partnership, a shareholder in a Professional Service Corporation or Association, or a member of a Professional Limited Liability Company? Yes No

If yes, provide name(s) of entity(s), tax identification number(s), and your relationship:

Name of entity	TID#	Relationship (partner, etc.)

List all other partners, shareholders, members, and all employed dentists for each entity (Indicate insurance carrier and Limits of Liability for each).

Name	Insurance Company	Limits of Liability Each Person/Total

Applicant Name: _____

Practice Information (continued)

PLEASE NOTE: Professional Corporation, Association or Partnership Coverage Information

The individual dentist policy issued by the Company affords coverage to your professional corporation, association or partnership named as a Qualified Professional Entity on your policy without additional premium charge. The professional corporation, association or partnership is not provided separate Limits of Liability, rather it shares the Limits of Liability with all other persons insured under your policy.

A separate additional set of Limits of Liability, not shared with other insureds, may be available to a professional corporation, association or partnership composed of two or more dentists (not available to a solo corporation) for an additional premium. (Please refer to the Company for information.)

I have considered the options available to me as described above and *I wish to select the following coverage* for my professional corporation, association or partnership.

- Shared Limits of Liability at no additional cost to me.
- Additional Limits of Liability for an additional premium (Please contact the Company for information.) A separate application is required.

I certify by checking this box that this is the desire of each member of my professional corporation, association or partnership and will be reflected similarly on their applications for insurance.

What is your primary practice specialty? (choose a description from the chart below) _____

Indicate the percentage of your time involved in the areas of practice shown below (percentages must total 100%):

Specialty Area of Practice	<input type="checkbox"/> Yes <input type="checkbox"/> No	% of time	Specialty Area of Practice	<input type="checkbox"/> Yes <input type="checkbox"/> No	% of time
(1) General Dentistry	<input type="checkbox"/> Yes <input type="checkbox"/> No	%	(8) Orthodontics	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
(2) Anesthesiology*	<input type="checkbox"/> Yes <input type="checkbox"/> No	%	(9) Pediatric Dentistry	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
(3) Cosmetic Dentistry	<input type="checkbox"/> Yes <input type="checkbox"/> No	%	(10) Periodontics	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
(4) Endodontics	<input type="checkbox"/> Yes <input type="checkbox"/> No	%	(11) Prosthodontics	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
(5) Implantology	<input type="checkbox"/> Yes <input type="checkbox"/> No	%	(12) Public Health	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
(6) Oral or Maxillofacial Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	%	(13) T.M.D.*	<input type="checkbox"/> Yes <input type="checkbox"/> No	%
(7) Oral Pathology	<input type="checkbox"/> Yes <input type="checkbox"/> No	%	(14) Other* (describe)	<input type="checkbox"/> Yes <input type="checkbox"/> No	%

* Please explain procedures performed for anesthesiology, T.M.D. and/or Other:

Practice Specialty Information:

a. Do you do full mouth rehabilitation solely for cosmetic purposes? Yes No

If yes, please explain:

Practice Information (continued)

b. Do you perform the following procedures? (please mark all that apply):

- Diagnostic, Preventative and/or Restorative Non-Invasive Procedures (ex. Non-Surgical TMJ treatments - mouth guards and splints, Cosmetic Whitening Veneers, Botox, Collagen or Restylane) Yes No
- Simple Extractions - no extraction of full or partial third molar impacted teeth Yes No
- Root Canals Yes No
If yes, percent of practice? Less than 10% 10 - 50% Over 50%
- Restorative Implants Yes No
If yes, percent of practice? Less than 10% 10 - 50% Over 50%
- Extractions of partial third molar impacted teeth Yes No
If yes, percent of practice? Less than 10% 10 - 50% Over 50%
- Placing Implants Yes No
If yes, percent of practice? Less than 10% 10 - 50% Over 50%
- Extractions of full third molar impacted teeth Yes No
If yes, percent of practice? Less than 10% 10 - 50% Over 50%
- Bone graft or sinus elevation surgeries Yes No
If yes, percent of practice? Less than 10% 10 - 50% Over 50%

c. Do you assist oral surgeons in surgery? Yes No

If yes, please explain:

Anesthesia Usage

a. Do you administer General Anesthesia or Deep Sedation to patients? Yes No

If yes, a separate application is also required. Coverage may be provided for an additional premium. Please contact the Company for information

b. Do any of your employees administer General Anesthesia or Deep Sedation to patients? Yes No

If yes, please provide name(s):

Name: _____

Name: _____

Name: _____

For all names listed above, attach copies of certification/license to provide General Anesthesia, and copy of current declarations page from professional liability carrier listing name, policy number, effective dates and limits of coverage.

(Please note that you will not be covered for your liability arising out of the acts or omissions of an employee(s) who administers General Anesthesia/Deep Sedation to patients, unless that person(s) is properly certified and licensed in NYS to do so, and insured against liability under separate valid and collectible professional liability coverage of at least the same amount as the Limits of Liability of your policy.)

c. Do you or any of your employees perform procedures on patients under General Anesthesia or Deep Sedation? Yes No

If yes, please indicate number of procedures performed annually: In hospital _____ In office _____

Practice Information (continued)

d. Do you administer Conscious (moderate) Sedation? Yes No

e. Do any of your employees administer Conscious (moderate) Sedation? Yes No

If yes, please list name(s) of persons administering Conscious (moderate) Sedation:

Name: _____

Name: _____

Name: _____

For all names listed above, please attach copies of current NYS certification to provide Conscious (moderate) Sedation, and copy of current declarations page from professional liability carrier listing name, policy number, effective dates and limits of coverage.

f. If you answered yes to questions d. and/or e. above, please answer the following:

1) Percentage of patients who receive Conscious (moderate) Sedation _____ %

2) Types of Conscious (moderate) Sedation (*Percentages must total 100%*)

- a) Intramuscular _____ %
- b) Intravenous/parenteral _____ %
- c) Nitrous oxide _____ %
- d) Enteral _____ %
- e) Combination of above _____ %

3) As respects to intramuscular and intravenous sedation, please provide estimated number of patients administered to annually:

	Intramuscular Sedation	Intravenous Sedation
a) number of patients in your office	_____	_____
b) number of patients in a hospital	_____	_____

Other than yourself, are there any professional employees or independent contractors in your practice? Yes No

If yes, indicate the number. If none, enter zero ("0").

Category	No. of Employees	No. of Independent Contractors
a) Oral Maxillofacial Surgeons	_____	_____
b) Dentists Using General Anesthesia/Deep Sedation	_____	_____
c) Dentists Using Conscious (moderate) Sedation	_____	_____
d) Dentists - All Others	_____	_____
e) Dental Assistants	_____	_____
f) Nurse Anesthetists	_____	_____
g) Dental Hygienists	_____	_____
h) Technicians - X-Ray	_____	_____
i) Other (describe below)	_____	_____

Describe Other: _____

Applicant Name: _____

Underwriting Information

Please note that you will not be covered for your liability as the owner, director, trustee, proprietor, superintendent, or officer of any hospital, sanitarium, dispensary, clinic, nursing home, laboratory, or any other business enterprise. See policy exclusion

Please note that the coverage afforded for the liability of others which you have assumed under a contract agreement is limited. See policy exclusion

I acknowledge I have read and agree to the terms above.

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS, PLEASE PROVIDE DETAILS IN THE SPACE PROVIDED

Have you ever been convicted of a criminal offense other than a motor vehicle violation? Yes No
If yes, please describe:

Have you ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms, or have you ever voluntarily surrendered same? Yes No
If yes, please describe:

Have you ever been denied a professional license, certification by a Specialty Board or membership in any professional society or association? Yes No
If yes, please describe:

Has any hospital or other health care facility ever restricted, suspended or revoked your privileges, or placed you on probation? Yes No
If yes, please describe:

Have you been investigated by any government agency, including a State Board? Yes No
If yes, please describe:

Have you ever voluntarily surrendered your hospital or other health care facility privileges, narcotics or professional license to avoid suspension, restriction, probation or revocation? Yes No
If yes, please describe:

Has any insurance company ever declined your application, canceled, refused to renew, restricted coverage or offered professional liability insurance to you with a deductible or at higher than regular rates? Yes No
If yes, please describe:

Have you ever practiced without insurance? Yes No
If yes, please describe:

Applicant Name: _____

Loss Information - Claims/Suits

Do you have any claims/suits that have been reported to any previous insurance carrier(s)? Yes No

If yes, list ALL malpractice claims or suits asserted against you, and attach copy of claims loss history from your carrier(s).

(a) Include any claims/suits that have been closed with or without payment; and

(b) any claims/suits that are currently pending.

Do not include any claims/suits that occurred during an internship, residency or fellowship.

Incident Date	Report Date	Status	If Closed		Insurance Carrier	Claimant Name
			Date Closed	Amount Paid On Your Behalf		
		<input type="checkbox"/> Pending <input type="checkbox"/> Closed				
Briefly describe allegations & care/treatment:						
		<input type="checkbox"/> Pending <input type="checkbox"/> Closed				
Briefly describe allegations & care/treatment:						
		<input type="checkbox"/> Pending <input type="checkbox"/> Closed				
Briefly describe allegations & care/treatment:						
		<input type="checkbox"/> Pending <input type="checkbox"/> Closed				
Briefly describe allegations & care/treatment:						
		<input type="checkbox"/> Pending <input type="checkbox"/> Closed				
Briefly describe allegations & care/treatment:						

See addendum for additional claims.

Applicant Name: _____

Loss Information - Claims/Suits (continued)

Incident Date	Report Date	Status	If Closed		Insurance Carrier	Claimant Name
			Date Closed	Amount Paid On Your Behalf		
		<input type="checkbox"/> Pending <input type="checkbox"/> Closed				
Briefly describe allegations & care/treatment:						
		<input type="checkbox"/> Pending <input type="checkbox"/> Closed				
Briefly describe allegations & care/treatment:						
		<input type="checkbox"/> Pending <input type="checkbox"/> Closed				
Briefly describe allegations & care/treatment:						
		<input type="checkbox"/> Pending <input type="checkbox"/> Closed				
Briefly describe allegations & care/treatment:						
		<input type="checkbox"/> Pending <input type="checkbox"/> Closed				
Briefly describe allegations & care/treatment:						
		<input type="checkbox"/> Pending <input type="checkbox"/> Closed				
Briefly describe allegations & care/treatment:						

Applicant Name: _____

Loss Information - Incidents/Events (continued)

Incident Date	Report Date If Carrier Notified	Insurance Carrier	Claimant Name
Briefly describe incident:			
Briefly describe incident:			
Briefly describe incident:			
Briefly describe incident:			
Briefly describe incident:			
Briefly describe incident:			